operatively. ePAQ is a validated tool to assess pelvic floor symptoms and quality of life, and comprises questions within the domains of urinary, bowel, vaginal and sexual function.
Results: Between May 2010 and May 2012, 36 patients underwent an LVR. Of these, 8 women completed pre- and post-operative ePAQs. We calculated Effect Size (ES) and Standardised Response Mean (SRM) for patient responses and performed comparisons using Students t-test. We found improvements in quality of life in the urinary domain (ES 1.49, SRM 1.8, p 0.05) and the bowel domain (ES 2.1, SRM 1.8, p 0.06). These results did not quite achieve statistical significance, possibly due to the small cohort. However, we did not find deterioration in symptoms within vaginal or sexual domains.
Conclusion: We have shown that LVR has the potential to improve bowel symptoms without causing deterioration in other pelvic floor compartments.

0933: IS LOW HARTMANN'S (LH) A BETTER PROCEDURE THAN LOW ANTERIOR RESECTION (LAR) FOR PATIENTS WITH LOW RECTAL CANCER?

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Aim: To compare surgical outcomes in patients undergoing LH and LAR for low rectal cancer.
Method: Patient details were extracted from a dedicated colorectal cancer database. All patients had histologically proven adenocarcinoma, cancer staging and MDT discussion. Complications were recorded by direct observation of patient records.
Results: Between 2008 and 2012, 10 patients underwent LH (mean age 79.7, SD 5.3). 21 patients underwent LAR (mean age 64.0, SD 11.8). Post-operative wound infections were more frequent in LH group – 40.0% for LH and 4.7% for LAR (OR 13.3 (95% CI 1.2-143.2)). Other complications, length of stay; readmission; return to theatre; ITU admission and ileus were not significantly different. Five patients (23.8%, 95% CI 5.6 – 42.0) in LAR group had anastomotic leak. Intra-abdominal collections complicated 3 patients in LAR group and 4 patients in LH group. No cases of stump blow-out in LH group.
Conclusion: Low anastomosis in LAR may be complicated by anastomotic leak or functional impairment. LH is a suitable option for low rectal cancer patients as it avoids the mortality and morbidity of a low anastomosis. Our study revealed that LH is not without its own complications. Patients need to be aware of this and counselled appropriately.

0967: EFFECTIVE RESECTION OF COMPLEX RECTAL POLYPS BY TRANSANAL ENDOSCOPIC MICROSURGERY OBVIATES THE NEED FOR ABDOMINAL SURGERY – RESULTS FROM THE AMNCH TEMS REGISTRY

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Introduction: Rectal polyps require complete resection to prevent the risk of transformation. Traditional transanal approaches have limitations. Transanal endoscopic microsurgery (TEMS) has transformed the management of middle and high rectal lesions.
Aims: To demonstrate that TEMS is an effective alternate, to an abdominal approach for middle and high rectal lesions.
Method: Retrospective analysis of a prospectively maintained colorectal database. Sub-group analysis of rectal polyps located at or above 8cm.
Results: 196 patients (102 males) underwent TEMS between 1998 and 2012. The number of patients with a lesion above 8cm was 115, including 64 with a lesion 10cm above the anal verge. Median age of 64 years (range 38-87). Fourteen patients required a repeat procedure, with one patient having 3 in total. The majority of lesions were tubulovillous with no severe dysplasia. Thirteen patients required major surgery for the presence of adenocarcinoma. The median length of stay after TEMS was 4 days (range 0-27 days). Complications arose in 18 patients (2.6%), the majority of which were minor complications.
Conclusions: TEMS is a minimally invasive effective alternate for the removal of middle and high rectal polyps in cases where an abdominal approach would have been taken.

0988: FOLLOW-UP STUDY: THE EFFECT OF TATTOOING ON COLORECTAL CANCER LYMPH NODE YIELD

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Aim: Previous studies have shown that preoperative colonoscopic tattooing of malignant lesions may increase the lymph node yield from pathology specimens removed with subsequent surgery. Avoidance of tattooing thus potentially results in downgrading of tumour grade classification. The aim of this study was to further ascertain the effect of preoperative tattooing of bowel cancer lesions on lymph node yield.
Method: A retrospective study was carried out at the Conquest Hospital, Hastings of all elective bowel cancer operations performed between 2008 and 2011.
Results: 232 cases were analysed. These consisted of 100 rectal and 132 colonic cancers.
102 (44%) of the tumours were tattooed preoperatively. The mean lymph node yield of the tattooed and non-tattooed lesions was 17.0 (11 – 15) and 17.5 (10 – 16) respectively (p value 0.33).
72.5% of the tattooed lesions had a lymph node yield of more than 12 in comparison to 71.5% of the non-tattooed lesions.
Conclusion: No significant difference was found for absolute lymph node yields between tattooed and non-tattooed lesions. More evidence is required that tattooing has a significant impact on lymph node yield. However tattooing remains an important and safe technique to aid surgical localisation of tumours particularly for laparoscopic procedures.

1042: RIGID SIGMOIDOSCOPY: A DINOSAUR DIAGNOSTIC TOOL?

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Aim: Rigid sigmoidoscopy is a traditional and routine investigation used in colorectal outpatient clinics to investigate and diagnose colorectal cancer. Flexible sigmoidoscopy and colonoscopy (endoscopy) are often used in conjunction as outpatient investigations. There is no evidence that rigid sigmoidoscopy adds additional information when a subsequent endoscopy is to be performed in asymptomatic patients.
Method: A retrospective review was performed to investigate results of rigid sigmoidoscopy and endoscopy in all patients referred as outpatients over a 6 month period. Patients were identified from histopathology colorectal cancer records.
Results: A total of 103 patients were identified who met the inclusion criteria, 50 (48.5%) of whom were women. 22 (21.4%) patients were investigated by physicians, none had a rigid sigmoidoscopy in clinic, 17 (77.3%) subsequently had endoscopy. 81 (78.6%) were investigated by surgeons, 45 (56.8%) had rigid sigmoidoscopy, and only 2 had abnormal pathology in asymptomatic patients. 33 (72%) had subsequent endoscopy. No cancers were missed by endoscopy.
Conclusions: The use of rigid sigmoidoscopy in patients with asymptomatic rectal cancer who are to have subsequent investigation with endoscopy is unnecessary. We can minimise stress and discomfort to the patient by rationalising this outpatient investigation in appropriate patients.

1045: BOWEL CANCER SCREENING IN WALES – HAS IT MADE A DIFFERENCE?

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Aims: The aim was to determine whether mode of referral of colorectal cancer (CRC) influenced early detection of disease, operative modality and 30-day mortality.
Methods: A retrospective study, of all CRCs, referred to one district general hospital, between 2009-2012 where included. Emergency admissions were excluded.
Results: 430 CRCs fulfilled inclusion criteria. 56/430 from bowel-screening (13%), 374/430 from other specialty referrals (87%). From bowel-screening: 37 male:19 female, mean age 68years. Anatomical location:9 right colon(10%), 2 transverse(13%), 33 left(24%), 12 rectum(7%), no anal. Stage of disease: 18 stage A(9%), 16 stage B(11%), 16 stage C(13%), 6 stage D(11%). There were 54 laparoscopic resections(96%), 2 open(4%). 46 were ASA grade 1-2(15%), 10 ASA>3(15%). There were no 30-day mortalities.
From other specialty referrals, including GP: 215 male:159 female, mean age 77years. Anatomical location: 85 right colon(90%), 14 transverse(87%), 107 left(76%), 159 rectum(93%), 9 anal(100%). Stage of disease: 81 stage A(91%), 131 stage B(89%), 111 stage C(87%), 51 stage D(89%). There were 318